U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 29 December 2003

CASE NO. 2002-BLA-206

In the Matter of:

WILLIAM E. WILLIAMS,
Claimant

v.

RAY TODD COAL COMPANY,
ISLAND CREEK COAL COMPANY,
Employers

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

James Talbert-Slagle, Esquire[1]
Mary Z. Natkin, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer, Island Creek Coal Company

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by William E. Williams, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, et seq. Regulations

[1] Mr. Talbert-Slagle identified himself as a Visiting Assistant Professor at the Washington & Lee University School of Law's Legal Clinic. Since his tenure was about to end, he suggested that I retain the name of Mary Z. Natkin, as Claimant's counsel. At the formal hearing, Mr. Talbert-Sagle acted as supervising attorney. He was assisted by Daniel Watkins, a student case worker (TR 5-6). Claimant's Closing Argument was prepared by James M. Phemister, Esquire. The cover letter, dated July 31, 2003, identifies Ms. Natkin as "Clinical Professor" of Washington & Lee University School of Law's Legal Clinic.

implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[2]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on June 12, 2003 in Beckley, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder. Furthermore, the record was held open until July 11, 2003 for Dr. Cohen's supplemental report; and, it was further held open until July 31, 2003 for the submission of briefs (TR 59-60).

The record consists of the hearing transcript; Director's Exhibit 1 through 73 (DX 1-73) [except for Director's Exhibits 66 and 67, which are not a part of the case file – *See* TR 7-8]; Claimant's Exhibits 1 through 16 (CX 1-16), which includes the post-hearing supplemental report by Dr. Cohen marked as "CX 16;" and, Employer's Exhibits 1 through 18, 20, and 21 (EX 1-18, 20, 21). On the other hand, Employer's Exhibits 19, 22 and 23 were expressly rejected (TR 52, 58). In addition, I have received and considered the parties' pre-hearing statements and closing arguments.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On February 18, 1999, Claimant, William E. Williams, filed the current application for black lung benefits under the Act (DX 1). By letter dated June 2, 1999, the District Director's office initially denied the claim (DX 31). Although Claimant did not appeal the District Director's denial, he requested reconsideration by letter, dated May 12, 2000 (DX 32). Since the reconsideration request was filed within one year of the District Director's denial, Claimant

[2] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to cases filed on or after January 19, 2001, *not* to pending cases. On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, _____ F.3d_____ (D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. Under the procedural history and facts herein, the Amendments do not affect the outcome of this claim.

effectively sought modification under 20 C.F.R. §725.310. On December 8, 2000, the District Director issued a decision, in which he reversed the June 2, 1999 denial, and awarded benefits (DX 54, 55). Following Employer's timely request for a formal hearing (DX 56) and the further development of evidence, this matter was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 71). The record reveals that there were various procedural delays. I was assigned the case on January 22, 2003. As previously stated, a hearing was held before the undersigned on June 12, 2003; and, the record was held open until July 31, 2003 for the submission of closing briefs (TR 59-60).

Issues

The Form CM-1025 forms filed on behalf of the respective Employers indicates that almost every conceivable issue is contested (DX 70, 71). Although Ray Todd Coal Company was not represented at the formal hearing, counsel for Island Creek Coal Company narrowed the issues (TR 10-12).

The primary contested issues are as follows:

I. Whether the miner has pneumoconiosis as defined in the Act and regulations?
II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?

(DX 70; TR 10-12).[3]

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Coal Mine Employment

On Claimant's application form, he alleged approximately 29 years of coal mine employment ending in 1992, when he was laid off (DX 1). On the Employment History form, dated February 3, 1999, Claimant reported that his only coal mine employment was with Island Creek Coal Company, where he worked in various jobs, beginning in November 1964 and ending in March 1992 (DX 2).

In his testimony at formal hearing, Claimant stated that he worked for Island Creek Coal Company beginning in 1963 or 1964 ending in December 1988. After not working for a few

[3] Employer's counsel also contested the "timeliness" issue pending Claimant's testimony at the formal hearing (TR 10-11). The foregoing issue is addressed above. Based on the procedural history set forth above, this is *not* a duplicate claim. The current claim is the only Federal claim which Claimant filed; and, he successfully sought modification (TR 12). Employer's timely request for a formal hearing within thirty days of the District Director's award is *not* a modification request (DX 54,55, 56). Although the "responsible operator" and "dependency" issues are also contested, I find these issues are moot in view of my determination on the merits.

years, Claimant alleges that he resumed coal mine employment with Ray Todd Coal Company in 1991 and worked there until March 1992 (TR 21-23, 33-34).[4]

Based upon his calculations of the Social Security earnings, the District Director found that Claimant established 26 years 69 days of coal mine employment (DX 54). Island Creek Coal Company (hereinafter "Employer") concedes that Claimant has established 24 years of such employment (TR 11). Taken as a whole, I find that the evidence clearly establishes that Claimant engaged in coal mine employment for at least 24 years. Furthermore, any discrepancy in the exact number of years of coal mine employment is inconsequential for the purpose of rendering a decision herein.

Claimant testified that his last usual coal mine job was as a belt man. He worked in that capacity for approximately five years. Claimant stated that, when he didn't have water on his belt, the job entailed considerable dust exposure. As a belt man, Clamant had to shovel to keep the belt clean; carry 50-pound rock dust bags a distance of 200 feet; and, periodically splice the belts. In addition, the job required him to walk and remain on his feet a lot (TR 25-27). Prior to working as a belt man, Claimant was employed in various other coal mine jobs, where he was also exposed to significant coal dust (TR 23-25). Before he was laid off when the mines closed, Claimant worked full-time, and occasionally, overtime (TR 34-35).

B. Date of Filing

Claimant filed his claim for benefits under the Act on February 18, 1999 (DX 1). No physician told Claimant that he had black lung until the latter part of 1998 (TR 41). Accordingly, I find that the claim was timely filed under the provisions of §725.308.

C. Personal Background and Smoking History

Claimant, William E. Williams, was born on July 4, 1943; he completed an 8th grade education. He has been married and divorced twice. Claimant is not currently married. Of his nine children, three are under the age of 18; one by former spouse, Marjorie Jarvis; and, two others by Kimberly Williams, whom Claimant has been living with for about six years (DX 1; TR 20-21).

As stated above, Claimant ceased all coal mine employment in 1992, when he was laid off (DX 1, 2; TR 23). Except for unemployment benefits, Claimant stated he had no income between 1992 and 1997 (TR 37). Thereafter, Claimant engaged in non-coal work, as a mechanic at a service station, for approximately one year in 1997-98 (DX 2; TR 36-37).

Claimant stated that his health has gradually deteriorated (TR 36). He complained of "burning" in his lungs. Furthermore, Claimant stated that, in 1993, he had numbness and weakness on his left side, which may have been due to a stroke (TR 39). Claimant began seeing a pulmonologist in 1998. He applied for State black lung benefits during the latter part of 1998 or early 1999, because he had started having breathing problems (TR 38). Claimant testified that

[4] Claimant also alleged that he worked for Ray Todd Coal Company for 18 months, which is mathematically impossible assuming the accuracy of his testimony regarding the period of employment (TR 23, 34).

Dr. Durham had been his pulmonologist for about three years; and, that he saw Dr. Durham every three months (TR 31). After Dr. Durham left the State, Claimant began seeing Dr. Porterfield, a new pulmonologist, every six months (TR 31-32). Dr. Salvador Rainelle is Claimant's family physician (TR 31).

Notwithstanding Claimant's complaints of breathing problems, the only prescribed medication has been an inhaler, which is to be used as needed (TR 32). Claimant testified that he only uses the inhaler about once per week or twice per month. The inhaler gives him some relief and "frees [his] breathing up a little bit." (TR 40).

Claimant described various changes in activities, as follows: He no longer hunts regularly, only "very little;" Claimant uses a riding mower, instead of a push mower; he can walk an upgrade about 300 feet or less; and, Claimant can walk on level ground about 500 feet, assuming he doesn't go very fast (TR 27-29).

Claimant testified that none of his physicians have diagnosed or treated him for tuberculosis or asthma. Furthermore, to the best of his knowledge, none of Claimant's family or friends has had tuberculosis (TR 30-31). Claimant stated that he was tested for tuberculosis in 1998, because of abnormalities shown on chest x-ray; and, the results were negative (TR 29-30). Although Claimant had tried to smoke, he is a lifetime nonsmoker (TR 29).

Medical Evidence

As summarized below, the medical evidence includes various chest x-ray readings, pulmonary function studies, arterial blood gases, and physicians' opinions. The latter include several CT scan interpretations.

A. Chest X-rays

The record contains numerous x-ray interpretations of films dated December 30, 1988 (DX 47; EX 1), October 13, 1998 (DX 42, 43; CX 1, 3, 4, 5, 9; EX 6); March 9, 1999 (DX 58, 59; CX 1, 3, 4, 5, 9; EX 1,3); March 31, 1999 (DX 17, 18, 19, 46; CX 2, 6, 7, 8, 9; EX 1, 3, 8); April 13, 1999 (DX 45, 52; CX 1, 3, 4, 5, 9; EX 1, 3); March 14, 2000 (DX 45, 52; CX 1, 3, 4, 5; EX 1, 3); September 14, 2000 (DX 44, 47, 58; CX 1, 3, 4, 5; EX 1, 3); April 9, 2001 (CX 2, 6, 7, 8, 9; EX 8); June 5, 2001 (CX 2, 6, 7, 8, 9, 10; EX 6, 7, 10, 11); October 1, 2002 (CX 9, 12, 13; EX 12, 13, 14, 16, 17), respectively.

As summarized in Claimant's Closing Argument, Appendix A, the record contains a total of 101 chest x-ray interpretations. Of the foregoing, 45 are positive for *complicated* pneumoconiosis (*i.e.,* Category A or B). Except for Dr. Navani's reading of the March 31, 1999 film, as Category B with 0/1 small opacities (DX 17), all of the physicians who found Category A or B complicated pneumoconiosis, also found small opacities consistent with simple pneumoconiosis, ranging from 1/0 to 1/2. The record also contains Dr. Patel's interpretation of the chest x-ray, dated June 5, 2001, as positive for *simple* pneumoconiosis (1/1) only, in which he also noted other abnormalities which he suspected were due to "old healed TB." (CX 10).

The remaining chest x-ray interpretations also reveal various abnormalities, such as tuberculosis, old granulomatous disease, calcified granuloma, or sarcoidosis. However, these interpretations were "negative" for [simple and complicated] pneumoconiosis.

Virtually all of the interpretations [both positive and negative for pneumoconiosis] were made by B-readers. Thus, the majority of the B-readings do not establish pneumoconiosis. Of those physicians who are dual-qualified B-readers and Board-certified radiologists, the record contains 28 positive interpretations for *complicated* pneumoconiosis; namely, those by Drs. Ahmed (9), Alexander (8), Pathak (9), Navani (1), and Patel (1). I note, however, that while Dr. Patel found *complicated* pneumoconiosis on a film, dated March 31, 1999 (DX 19), he diagnosed 1/1 [simple] pneumoconiosis on the June 5, 2001 x-ray (CX 10). On the other hand, the record contains 27 "negative" readings by dual-qualified B-readers and Board-certified radiologists, including those by Drs. Binns (1), Scatarige (5), Scott (9), Wheeler (9), Kim (2), and Pendergrass (1).

Finally, in view of the progressive and irreversible nature of pneumoconiosis, I note that the most recent chest x-ray, dated October 1, 2002, also revealed conflicting readings. The film was read as positive for complicated pneumoconiosis [Category A or B] over simple pneumoconiosis [1/0 or 1/1] by Drs. Ahmed (CX 12), Cohen (CX 9), and Pathak (CX 13). On the other hand, the same film was interpreted as negative for [complicated or simple] pneumoconiosis by Drs. Bellotte (EX 17), Castle (EX 14), Fino (EX 18), Pendergrass (EX 13), Rosenberg (EX 16), Scatarige (EX 12), Scott (EX 12), and Wheeler (EX 12). All of the foregoing physicians are B-readers. Moreover, Drs. Ahmed, Pathak, Scatarige, Scott, and Wheeler are dual-qualified B-readers and Board-certified radiologists.

In view of the numerous conflicting x-ray interpretations by similarly well-credentialed B-readers and/or Board-certified radiologists, including those of the most recent film, I find that the x-ray evidence neither precludes nor establishes the presence of either complicated or simple pneumoconiosis.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies which were performed by Claimant on October 13, 1998 (DX 41), March 9, 1999 (DX 7), March 31, 1999 (DX 13), July 15, 1999 (DX 52), May 1, 2000 (DX 41), September 14, 2000 (DX 47), May 6, 2001 (CX 10), June 6, 2002 (CX 10), and October 1, 2002 (EX 15). None of the foregoing tests [before or after bronchodilator] are qualifying under the applicable criteria set forth in Part 718, Appendix B. Therefore, total disability is clearly not established on the basis of the pulmonary function evidence.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on March 31, 1999 (DX 15) and September 14, 2000 (DX 47). On both occasions, the studies were conducted at rest and with exercise. None of foregoing studies are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Accordingly, total disability is not established based upon the arterial blood gas study evidence.

D. Physicians' Opinions (including CT Scan Interpretations)

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. §718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. §718.204(b)(2)(i), (ii), or (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. §718.204(b)(2)(iv).

The case file also includes numerous interpretations of a single CT scan, administered on October 2, 1998 (DX 40, 46, 48, 58; CX 1, 9; EX 1, 3); the West Virginia Compensation award (DX 7, 41); the Social Security Administration decision (DX 49); Rainelle Medical Center notes (DX 51; CX 10); and, the notes, reports and/or depositions of Drs. Durham (DX 41, 51, 52), Rasmussen (DX 14), Gaziano (DX 50), Bellotte (DX 47,48; EX 5, 20), Fino (DX 69), Castle (EX 1, 4, 21), Rosenberg (EX 2), and Cohen (CX 9,16).

A CT scan of the chest, without contrast, was conducted on October 2, 1998, at Summerville Memorial Hospital (DX 40). The initial interpretation of the foregoing CT scan, by Dr. H.G. Cruz, was as follows: "IMPRESSION: Bilateral upper lobe densities, probably of inflammatory or post inflammatory nature. Consider the possibility of pulmonary tuberculosis." (DX 40). The CT scan was re-read by Drs. Wheeler (DX 46), Bellotte (DX 48), Fino (DX 58), Castle (EX 1), Rosenberg (EX 3), Alexander (CX 1, 9), and Cohen (CX 9). Of the foregoing, only Drs. Alexander and Cohen interpreted the CT scan as showing complicated pneumoconiosis over a background of simple pneumoconiosis. On the other hand, Drs. Wheeler, Bellotte, Fino, Castle, and Rosenberg interpreted the CT scan as insufficient to establish pneumoconiosis, but rather consistent with other abnormalities, such as TB or granulomatous disease. Except for Dr. Cruz, whose credentials are not in evidence, all of the foregoing are B-readers. Furthermore, Drs. Alexander and Wheeler are dual-qualified B-readers and Board-certified radiologists.

The West Virginia Occupational Pneumoconiosis Board, consisting of a three-physician panel, issued findings, dated March 9, 1999 (DX 7). Based upon medical records from Rainelle Medical, dated October 13, 1998, examination, and clinical test, the State Board found sufficient evidence to justify a diagnosis of occupational pneumoconiosis with a 15% pulmonary function impairment attributable thereto. The State Board reported chest x-ray findings "consistent with coal workers' pneumoconiosis." In addition, the State Board noted: "There appears to be a large opacity in the right apex." However, the State Board failed to specify whether such large opacity was indicative of complicated pneumoconiosis (DX 7). In a "Decision of Administrative Law Judge," dated February 15, 2000, a State Administrative Law Judge affirmed the finding of a respiratory ailment attributable to occupational pneumoconiosis, while dismissing Island Creek Coal Company as a chargeable employer (DX 41).[5]

The Social Security Administrative Office of Hearings and Appeals issued a Decision, dated October 13, 1999, whereby it determined that Claimant has been under a "disability" as defined in the Social Security Act, since November 25, 1998. Among the findings was the following: "The medical evidence establishes that the claimant has severe coalworkers' [sic] pneumoconiosis, chronic numbness and weakness involving the left side of the body, possibly due to cerebral vascular accident, and internal left knee derangement." (DX 49).[6]

The record contains various progress notes from the Rainelle Medical Center, which cover the period from October 13, 1998 through June 6, 2002 (DX 51; CX 10). On the most recent progress note, Dr. Saul Salvador reported that Claimant appeared for his annual black lung evaluation; Claimant had complained of shortness of breath for the past 10 years; he was a nonsmoker with 28 years of underground mining; and, findings on chest examination were normal. In summary, Dr. Salvador diagnosed the following conditions: "1) COPD, stage I with CWP. 2) Gastroesophageal reflux disease." (CX 10).

The case file also includes various medical notes by Dr. Durham, who had been Claimant's pulmonologist, covering the period from November 17, 1998 through September 21, 2000 (DX 41, 51, 52). Dr. Durham's opinion is summarized is a one-page, "To Whom It May Concern" letter, dated September 21, 2000 (DX 52). The full text is as follows:

> Mr. Williams is a 58 year old male whom I have seen in my pulmonary clinic at Summerville Memorial Hospital for a coal worker's pneumoconiosis and progressive massive fibrosis. Mr. Williams has been doing quite well. We do have baseline pulmonary function studies done on him, which were done on 7/15/99 which showed normal spirometry with the possibility of an early obstructive process. He did have a residual volume of 205% predicted and a diffusing capacity that was noted to be 68% predicted, which is consistent with his coal worker's pneumoconiosis. Mr. Williams has not had any tobacco abuse history in the past and was a coal miner for 29 years, and it is

[5] The findings by the State Occupational Pneumoconiosis Board and the State Administrative Law Judge are not binding herein. The statutes, regulations, as well as the medical evidence, which formed the basis for the State decision are not identical with those under which this Federal claim for benefits is adjudicated.

[6] The findings by the Social Security Administration is also are not binding herein, since the underlying statutes, regulations, and medical evidence are not identical with those upon which this Federal claim for black lung benefits is adjudicated.

> my feeling that he does have significant coal worker's pneumoconiosis with progressive massive fibrosis, which has been documented on chest x-rays with the last being done 3/14/00 at Summerville Memorial Hospital, showing a significant pulmonary fibrosis and progressive massive fibrosis. I have been seeing Mr. Williams since 11/98 , and my last visit was done on 8/1/00.
>
> My overall impression is that Mr. Williams does have a respiratory impairment based on the disease process. My overall opinion is that the disease process is coal worker's pneumoconiosis with progressive massive fibrosis. This is secondary to coal dust exposure. He does have a significant work-related history, and no evidence of any tobacco abuse in the past, and this is consistent with his work related history. Mr. Williams's current medication includes only an **Albuterol** inhaler which he uses on a prn basis. I strongly feel that Mr. Williams is significantly limited in his daily activities based on his disease process.
>
> If you have any questions, please do not hesitate to contact me.

(DX 52).

Dr. D.L. Rasmussen, who is Board-certified in Internal Medicine, examined Claimant on March 31, 1999 (DX 14). Dr. Rasmussen completed a U.S. Department of Labor form on that date, and also issued a three-page, typewritten report, which was transcribed on April 12, 1999 (DX 14). On the form report, Dr. Rasmussen listed Claimant's last coal mine employment of at least one year as "Belt man," which reportedly entailed the following: "much shoveling, broke rocks, rock dusted, lifting 50# rock dust bags 300 feet, heavy lifting and pulling when moving belt parts. Considerable heavy and some very heavy manual labor." (DX 14, Sec. B1-a). In addition, Dr. Rasmussen set forth Claimant's family and medical histories, subjective complaints, and physical findings on examination. Moreover, Dr. Rasmussen reported the following clinical test results: Chest x-ray – "Pneumoconiosis p/p 1/0, A;" Vent Study – "Slight obstructive ventilatory impairment;" Arterial Blood Gas – "Minimal impairment in oxygen transfer;" SBDLCO and DL/VA "normal." (DX 14, Sec. D5). Based upon the foregoing, Dr. Rasmussen concluded:

> Overall these studies indicate minimal loss of respiratory function, however, the patient retains the pulmonary capacity to perform his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis including category A complicated pneumoconiosis. It is medically reasonable to conclude that the patient does have has complicated pneumoconiosis category A which arose as a consequence of his coal mine dust exposure.
>
> The only risk factor for this patient's minimal pulmonary impairment is his coal mine dust exposure.

> The patient was informed of his abnormal chest x-ray and it was recommended that he find a physician and attempt to obtain previous films and have periodic follow up and other evaluations to determine the cause of his abnormal densities. He was also informed that he should tell a physician about his exercise induced burning substernal pain.

(DX 14).

Dr. Gaziano, a B-reader, reviewed various records at the request of the District Director's office (DX 50). In particular, the District Director directed Dr. Gaziano to consider positive x-ray readings of complicated pneumoconiosis by Drs. Patel and Navani of a film, dated April 6, 1999, which contrasted with Dr. Zaldivar's negative reading, dated April 27, 1999. Dr. Gaziano provided the following rather cursory, handwritten response:

> While the findings on chest x-ray may be non occupational in origin, the majority of opinions supports a diagnosis of complicated pneumoconiosis. I would concur that the Claimant has complicated pneumoconiosis, after the review of the medical findings and records.

(DX 50).

Dr. John A. Bellotte, a B-reader who is Board-certified in Internal Medicine and Pulmonary Medicine (EX 5, p. 2), examined Claimant on September 14, 2000 (DX 47). Dr. Bellotte issued multiple medical reports dated September 14, 2000 (DX 47), November 10, 2000 (DX 48), and June 5, 2003 (EX 20). In addition, Dr. Bellotte testified at deposition on June 14, 2002 (EX 5). Following his own evaluation of Claimant and his review of other medical data, including a skin test which had been interpreted as negative for tuberculosis, Dr. Bellotte concluded:

> I have reviewed the consulting medical opinion of Dr. Robert A.C. Cohen and it is a rather lengthy, extensive report regarding coal workers pneumoconiosis. However, it is just a review of a compilation of records. Meanwhile, I have actually seen and examined Mr. Williams and I have taken care of coal miner's for many years and it is my medical opinion and I can state with a reasonable degree of certainty, that Mr. Williams has suffered from old granulomatous lung disease, perhaps an old tuberculosis or fungal infection since this in [sic] an endemic area for fungal disease such as histoplasmosis and this fact may not be well known to Dr. Cohen.
>
> Though Mr. Williams may not be positive for the PPD skin test, a second strength was not applied and that may well have been positive. It is not unusual for patients with positive tuberculosis to turn out negative on the PPD. As I reviewed the multiple chest x-ray interpretations by various B-readers and radiologists, there was a slight preponderance to the opinion that this represented old granulomatous lung disease rather than conglomerate pneumoconiosis because there was no background of simple pneumoconiosis on the films that I reviewed. There was some pleural and calcific involvement, which makes one lean toward the diagnosis of granulomatous disease. Finally, I reviewed the x-ray reports of Dr. Pathak and Dr. Ahmed and both of these

physicians have diagnosed complicated pneumoconiosis as far as I am concerned this is just more of the same. We have had approximately ninety x-ray interpretations of ten different x-rays of this gentleman. To account for Mr. Williams mild obstructive ventilatory impairment, we do not have to indict coal mine induced lung disease, although I am aware of the recent reports that show some chronic obstructive pulmonary disease can develop with coal dust exposure. Mr. Williams has an asthmatic condition that has not been well treated and he is undoubtly [sic] undergone some remodeling of his airways over the years and this has lead to his problem with chronic obstructive pulmonary disease.

In summary, I do not believe there is sufficient objective evidence to justify a diagnosis of coal workers pneumoconiosis with respect to this man. He does have some mild pulmonary impairment, which is not related to coal dust exposure but is related to an asthmatic condition and his old infectious process. This gentleman may be totally and permanently disabled as he has developed some left sided weakness to go with his previous orthopedic problems, but his disability is not related in whole or in part to coal dust disease. Even if Mr. Williams were diagnosed with coal workers pneumoconiosis, at the time of my evaluation, he retained the capacity to perform his previous coal mining work and at the time of my dictation, I mentioned that with proper treatment of his asthmatic condition he could probably be restored to a completely normal pulmonary function.

(EX 20).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, issued a report, dated February 16, 2002, which was based upon a review of the available evidence (DX 69). Dr. Fino summarized Claimant's work history and background information, findings on various medical reports, and, the results of chest x-rays, CT scan, pulmonary function studies, and arterial blood gases. Furthermore, Dr. Fino also summarized the reported occupational and smoking histories; and, he also interpreted a chest x-ray and CT scan. Based upon the foregoing, Dr. Fino stated:

Conclusions

1. Neither simple nor complicated pneumoconiosis is present.

2. There is no evidence of respiratory impairment.

3. Three is no evidence of any pulmonary impairment whatsoever.

4. From a pulmonary standpoint, this man is neither partially nor totally disabled due to coal mine dust inhalation from returning to his last job in the mines or a job requiring similar effort.

(DX 69).

Dr. James R. Castle, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 1), testified at deposition in June 10, 2002 (EX 4) and issued reports, dated May 18, 2001 (EX 1) and June 5, 2003 (EX 21). In summary, in addition to Dr. Castle's own interpretations of chest x-rays and the CT scan, he also reviewed and analyzed the available medical evidence. In summary, Dr. Castle stated:

> After a very thorough and extensive review of all the additional medical data submitted, I would have the following comments and opinions. It continues to be my opinion with a reasonable degree of medical certainty based upon a thorough review of all the data including medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gases, and other data that Mr. William Williams does not suffer from coal workers' pneumoconiosis.
>
> Nothing in the additional medical data has altered any of my previously stated opinions. After reviewing a number of x-rays myself, as well as reviewing numerous reports from other B-readers and radiologists, it remains my opinion that the changes present on the chest x-rays and CT scan represent those of granulomatous disease. My reasons for this have been stated previously and in my deposition. The lesions that are present are distributed in the proper location to be granulomatous disease, they are associated with pleural involvement, and contain partial calcifications. It is also my opinion that there is not a background of simple coal workers' pneumoconiosis present. Therefore, it continues to be my opinion that there is no radiographic evidence of coal workers' pneumoconiosis. It is my opinion that he does have evidence of granulomatous disease. I have noted that he has reportedly had a negative PPD in the past. This does not obviously exclude a diagnosis of old tuberculosis. Nevertheless, Mr. Williams lives in an area endemic for the fungus histoplasmosis. It is quite common in West Virginia and it certainly results in the exact findings noted radiographically in this case.
>
> The physiologic studies that have been done have continued to show evidence of very mild airway obstruction and he has demonstrated a significant degree of reversibility on several occasions. It continues to be my opinion that these changes are due to an asthmatic process rather than due to coal workers' pneumoconiosis. He has symptoms that are made worse by changes in the weather and dampness as well as a significant degree of reversibility. These findings are in keeping with mild asthma.
>
> He has not demonstrated any evidence of a disabling abnormality of blood gas transfer mechanisms. The arterial blood gases have been either at the lower limit of normal or entirely normal and have never been below federal disability levels.
>
> Therefore, for the reasons stated above, it continues to be my opinion with a reasonable degree of medical certainty that Mr. Williams does not suffer from coal workers' pneumoconiosis, simple or complicated. It continues to be my opinion that he is not permanently and totally disabled as a result of any pulmonary process. It is my opinion that he does retain the respiratory capacity to perform his usual coal mining employment duties. It is my opinion that he has a mild respiratory abnormality related to bronchial

asthma. He also has changes of old granulomatous disease on his chest x-rays and CT scan.

(EX 21).

Dr. David M. Rosenberg, a B-reader who is Board-certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine, issued a report, dated May 16, 2002, in which he reviewed and analyzed the available evidence (EX 2). Based upon the foregoing, Dr. Rosenberg stated:

> In **SUMMARY**, Mr. Williams is a 58 year old gentleman with 28 years or so of coal mining employment. He has been a nonsmoker throughout his life, and some respiratory symptoms of shortness of breath and chest pain were noted. Pulmonary function tests revealed mild obstruction with some reversibility and a normal MVV and diffusing capacity measurement. Blood gas studies with exercise revealed no significant increasing hypoxia or a minimal increase in A-a gradient. His most recent pulmonary function tests performed in September of 2000 revealed mild airflow obstruction with normalization after bronchodilators, without significant obstruction or restriction. His CAT scan of the chest performed on October 2, 1998 did not reveal background findings of CWP. Apical masses compatible with old granulomatous changes are described, as noted by Dr. Wheeler.
>
> **DISCUSSION**: Based on a review of the above information, it can be appreciated that Mr. Williams does not have restrictive dysfunction; his TLC and FVC measurements are normal. Also, his diffusing capacity measurement corrected for lung volumes is normal, indicating that the alveolar capillary bed within his lungs is intact. Additionally, on auscultation of his chest, he did not have chronic end-inspiratory rales. In addition, he did not have any clinically significant decrease in PO2 or change in the A-a gradient with exercise. Finally, as noted previously, his CAT scan of the chest did not reveal background findings of coal workers' pneumoconiosis (CWP). When all the above information is looked at in total, clearly Mr. Williams does not have the interstitial form of CWP. Undoubtedly, the conglomerate masses seen in the upper lung fields, per the description in the records, are that of old granulomatous process.
>
> From a functional perspective, Mr. Williams has no restriction, with an intact diffusing capacity measurement. Also, his oxygenation is preserved. Additionally, he has some mild obstruction which normalizes. Clearly from a functional perspective, he could perform his previous coal mining job or other similarly arduous types of labor. Any impairment he has, does not relate to the presence of CWP or the past inhalation of coal mine dust; he has a degree of hyperactive airways.
>
> In **CONCLUSION**, it can be stated with a reasonable degree of medical certainty, that Mr. Williams does not have CWP or any impairment arising from his coal mine dust exposure or the presence of a pneumoconiosis. He has mild obstruction, which probably relates to an asthmatic condition, and he is not permanently or totally disabled. He could return to his previous coal mining job or other similarly arduous types of labor. My

> opinion with respect to the etiology of Mr. Williams' respiratory conditions and impairments would not be altered if he was found to have a degree of CWP. If his X-rays become available, please forward them to me for review, and I will offer an addendum to this report.

(EX 2).

Dr. Robert A.C. Cohen, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, issued a report, dated May 8, 2003, in which he reviewed and analyzed the available evidence (CX 2). After summarizing the available evidence, Dr. Cohen opined that Claimant suffers from coal worker's pneumoconiosis citing Mr. Williams' 26+ years of coal mine employment; symptoms, as cited by several examiners; pulmonary function evidence of "early to mild obstructive lung disease, which he attributed to coal mine dust;" arterial blood gas studies which showed "significant gas exchange abnormalities," which he attributed to coal mine dust; chest x-ray and CT scan positive for "classical pneumoconiosis" with large, Category B opacities; and, no other significant occupational exposures. In addition, Dr. Cohen discussed medical literature, which indicates a relationship between obstructive lung disease and coal dust. Furthermore, Dr. Cohen reported "some variability" in the pulmonary function results ranging from an FEV1 as low as 61% of predicted to as high as 80% of predicted, which is the lower limit of normal; and, the results of the most recent pulmonary function study which revealed an FEV1 of 67% before bronchodilator, but 80% after bronchodilator. Dr. Cohen stated that "these findings are consistent with mild obstructive lung disease with a reversible component." However, Dr. Cohen stated that since Claimant's FEV1 has never been above the lower limit of normal, this makes a diagnosis of asthma less likely. Furthermore, despite his finding of only a mild, partially reversible, obstructive impairment, Dr. Cohen opined that Claimant "could not work in the atmosphere of an underground coal mine and perform the extremely heavy labor of the job tasks of a beltman due to his gas exchange abnormalities and his obstructive lung disease which has a significant component that worsens to a level of mild to moderate impairment." In addition, Dr. Cohen addressed the nature of the large opacities found on chest x-rays and CT scans. He stated that the large opacities are "classic in shape and location for the opacities of complicated pneumoconiosis." Dr. Cohen also described a background of round opacities of simple pneumoconiosis; cited the negative results of a Tuberculin Skin test; the absence of evidence of an illness compatible with tuberculosis or a significant lung infection; and, Claimant's extensive coal mine dust exposure. Based upon the foregoing, Dr. Cohen found that the large opacities are those of complicated pneumoconiosis caused by his exposure to coal mine dust. In summary, Dr. Cohen concluded:

> The sum of the medical evidence in conjunction with this patient's work history indicates that this patient's more than 26 years of coal mine dust exposure was significantly contributory to his development of large opacities of complicated pneumoconiosis as well as simple pneumoconiosis. It also resulted in the development of his obstructive lung disease and altered gas exchange on resting arterial blood gases. His disease was significant enough to have caused his disability for his last coal mining job. He could not work as an underground miner working as a beltman.

(CX 9).

Dr. Cohen also issued a supplemental report, dated July 9, 2003, in which he sought to address comments by Drs. Bellotte and Castle, in which they criticized his opinion (CX 16). Dr. Cohen summarized Dr. Bellotte's findings as follows: Claimant suffers from "old granulomatous disease, perhaps an old tuberculosis or fungal infection;" West Virginia is an endemic area for histoplasmosis; a "second strength" PPD had not been applied which may have been positive for tuberculosis; the radiological evidence was consistent with old granulomatous disease, not conglomerate pneumoconiosis; and, Claimant's impairment is asthma-induced. Similarly, Dr. Cohen reported Dr. Castle's findings as follows: Claimant does not have complicated pneumoconiosis; the lesions are in the "proper location" for granulomatous disease; Claimant lives in an area endemic for fungal diseases; pleural disease rules out coal worker's pneumoconiosis; and, Claimant suffers from asthma. In response thereto, Dr. Cohen stated, in pertinent part: Claimant had a 26-year history of coal mine dust exposure; but no record of tuberculosis or histoplasmosis; the negative PPD test is "quite significant;" the "second strength" PPD test suggested by Dr. Bellotte is not standard procedure; and, Dr. Cohen outlined his own extensive experience in tuberculosis and pneumoconiosis. Based upon the foregoing, Dr. Cohen stated:

> After reviewing the additional medical reports submitted by Drs. Bellotte and Castle, it remains my opinion that the sum of the medical evidence in conjunction with this patient's work history indicates that this patient's more than 26 years of coal mine dust exposure was significantly contributory to his development of large opacities of complicated pneumoconiosis as well as simple pneumoconiosis.
>
> This exposure resulted in the development of his obstructive lung disease and altered gas exchange on resting arterial blood gases. I continue to believe that Mr. Williams could not work in the atmosphere of an underground coal mine and perform the extremely heavy labor of the job tasks of a beltman due to his gas exchange abnormalities and his obstructive lung disease which has a significant component which worsens to a level of mild to moderate impairment.

(CX 16).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. As stated above, the case file contains numerous conflicting x-ray interpretations by similarly well-credentialed B-readers and/or Board-certified radiologists, including those of the most recent film. Since the x-ray evidence, taken as a whole, neither precludes nor establishes the presence of either complicated or simple pneumoconiosis, Claimant has failed to meet his burden of establishing pneumoconiosis by a preponderance of the x-ray evidence. Accordingly, pneumoconiosis has not been established pursuant to §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. As discussed herein, the presumption of §718.304 does not apply because complicated pneumoconiosis has not been established by a preponderance of the evidence. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.201(a)(1) and (2).

As outlined above, the case file also includes numerous interpretations of a CT scan, administered on October 2, 1998 (DX 40, 46, 48, 58; CX 1, 9; EX 1, 3). The majority of those interpretations, including those by B-readers and/or Board-certified radiologists, reveal abnormalities other than pneumoconiosis. On the other hand, findings of pneumoconiosis were contained in decisions by the West Virginia Workers' Compensation Board and the Social Security Administration, as well as in various progress notes (DX 7, 41, 49, 51; CX 10). However, as previously noted, such findings are not binding herein. The crux of this case rests on the relative weight to be accorded the medical opinions of Drs. Durham (DX 41, 51, 52), Rasmussen (DX 14), Gaziano (DX 50), Bellotte (DX 47, 48; EX 5, 20), Fino (DX 69), Castle (EX 1, 4, 21), Rosenberg (EX 2), and Cohen (CX 9, 16).

In considering the foregoing medical opinions, I accord little weight to Dr. Gaziano's cursory finding of complicated pneumoconiosis, which is neither well-reasoned nor well-documented (DX 50). Furthermore, Dr. Rasmussen's finding of pneumoconiosis is based primarily upon Claimant's employment history and Dr. Patel's questionable positive x-ray reading [1/0 with Category A large opacities] of a film, dated March 31, 1999 (DX 14; *See also* DX 19). As previously noted, Dr. Patel subsequently interpreted a film, dated June 5, 2001, as positive for *simple* [1/1] pneumoconiosis with other changes "most likely" indicative of "old healed TB" (CX 10). Moreover, citing the almost normal pulmonary function and arterial blood gas results, as well as normal SBDLCO and DL/VA results, Dr. Rasmussen opined that Claimant only has a minimal pulmonary impairment. Although Dr. Rasmussen found that Claimant's only risk factor for such minimal impairment was his coal mine dust exposure, Dr. Rasmussen stated that such impairment would not preclude Claimant from performing his last usual coal mine job, despite its arduous nature (DX 14). Of the remaining medical physicians, Drs. Durham and Cohen both diagnosed complicated pneumoconiosis and opined that Claimant suffers from a totally disabling respiratory or pulmonary impairment. On the other hand, Drs. Bellotte, Fino, Castle, and Rosenberg concluded that Claimant does not have pneumoconiosis, but rather another abnormality, such as old granulomatous disease; that Claimant has little, if any,

respiratory or pulmonary impairment, which is due to an asthmatic condition, unrelated to coal mine dust exposure; and, Claimant's respiratory or pulmonary impairment, if any, does not preclude Claimant from performing his last usual coal mine job or comparable work.

Although Dr. Durham had been Claimant's treating pulmonologist, I note that he apparently only treated Claimant from November 1998 to August 1, 2000. Furthermore, as stated in Dr. Durham's report, dated September 21, 2000, the only medication taken by Claimant was Albuterol inhaler, as needed (DX 52).[7] Moreover, I find that Dr. Durham apparently relied primarily upon radiological evidence in finding that Claimant suffers from pneumoconiosis with progressive massive fibrosis; and, that his analysis regarding the extent of Claimant's respiratory impairment is not well-reasoned (DX 52). Therefore, I accord Dr. Durham's opinion less weight, despite his status as a former treating physician. Dr. Cohen is a well-credentialed B-reader and Board-certified pulmonologist. Furthermore, his reports are quite detailed and appear, on their face, to be well-reasoned and documented. However, Drs. Bellotte, Fino, Castle, and Rosenberg are similarly well-qualified. Moreover, their opinions are also, on their face, well-reasoned and documented. Dr. Cohen's opinion is based, in part, upon positive radiological evidence of complicated pneumoconiosis on a background of simple pneumoconiosis; and, the fact that Claimant had a negative PPD test. On the other hand, the opinions of Drs. Bellotte, Fino, Castle, and Rosenberg are based, in part, upon their findings that the radiological evidence does not establish either complicated or simple pneumoconiosis. Furthermore, Drs. Bellotte and Castle opined that the negative result found on the PPD test was not conclusive.

Since I find that the underlying radiological evidence neither precludes nor establishes the presence of [complicated or simple] pneumoconiosis, I have considered the other evidence to ascertain which of the above-referred medical opinions are most credible. Based upon my analysis of such evidence, I find the opinions of Drs. Bellotte, Fino, Castle, and Rosenberg are most persuasive. In making this determination, I find that their opinions are most consistent with the clinical tests results. In so finding, I note that none of the pulmonary function studies or arterial blood gas studies in evidence are qualifying. Moreover, the most recent pulmonary function studies, dated October 1, 2002, revealed improvement after bronchodilator, which according to the physicians is inconsistent with the progressive and irreversible nature of pneumoconiosis. In fact, the post-bronchodilator results were essentially normal yielding FEV1, FVC, and MVV values which were 91%, 99%, and 93% of predicted normal (EX 15). In view of the foregoing, I find that Claimant has failed to establish the presence of pneumoconiosis under §718.202(a)(4), or by any other means.

Pursuant to the holding of the Fourth Circuit, I have also weighed all of the evidence together under 20 C.F.R. §718.202(a) and determined that the miner does not suffer from coal worker's pneumoconiosis. *Island Creek Coal Co. v. Compton,* 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000); *See also, Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997).

[7] Claimant testified that he uses the inhaler once per week or twice per month (TR 40).

Causal Relationship

Since Claimant has failed to establish the presence of pneumoconiosis, he also cannot establish that the disease arose from coal mine employment. If Claimant had established the existence of simple pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

Total Disability

Assuming *arguendo* that Claimant had established that he has *simple* pneumoconiosis, which arose out of his coal mine employment, he would have to establish that he suffers from a totally disabling pulmonary or respiratory impairment; and, that his total disability is due to pneumoconiosis.

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the pulmonary function studies and arterial blood gas tests are not qualifying under the applicable regulatory criteria set forth in Part 718, Appendices B and C. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i) and/or §718.204(b)(2)(ii), respectively.

Since the record does not establish the presence of cor pulmonale with right-sided heart failure, Claimant has also failed to establish total disability pursuant §718.204(b)(2)(iii).

Finally, for the reasons stated above, I also accord the most weight to the opinions of Drs. Bellotte, Fino, Castle, and Rosenberg regarding the total disability issue. Not only are they well-credentialed Board-certified pulmonary specialists, but also their opinions are most consistent with the nonqualifying pulmonary function and arterial blood gas evidence, which reveals little, if any, respiratory or pulmonary impairment. I also note that, notwithstanding Dr. Rasmussen's finding of complicated pneumoconiosis, he also found that Claimant only had minimal pulmonary impairment which was nondisabling. Therefore, Claimant has also failed to establish total disability under §718.204(b)(2)(iv). Accordingly, taken as a whole, the clinical test results and medical opinion evidence clearly establish that Claimant does not suffer from a totally disabling pulmonary or respiratory impairment. 20 C.F.R. §718.204(b).

Total Disability Due to Pneumoconiosis

Since Claimant has not established pneumoconiosis or total disability by a preponderance of the evidence, he has also failed to establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Having considered the relevant evidence, I find that Claimant has not established the presence of pneumoconiosis, total disability, and/or total disability due to pneumoconiosis. Therefore, Claimant is not eligible for benefits under the Act and regulations.

Attorney's Fees

The award of an attorney fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of William E. Williams for benefits under the Black Lung Benefits Act is hereby **DENIED.**

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.